CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

Revised August 1, 2002

S. 710
Eliminate Colorectal Cancer Act of 2002

As ordered reported by the Senate Committee on Health, Education, Labor, and Pensions on July 10, 2002

SUMMARY

S. 710 would require group health plans and health insurance issuers to cover colorectal cancer screening at regular intervals for all plan enrollees over the age of 50 and for certain enrollees under the age of 50 who are at high risk of developing colorectal cancer. The bill would require insurers to adopt guidelines used in the Medicare program that specify the types and frequency of screening procedures that must be covered. The bill would not preempt state laws that require plans to provide more comprehensive benefits for colorectal cancer screening than the requirements of the bill.

Enacting S. 710 would affect the federal budget because it would result in higher premiums for employer-sponsored health benefits. Higher premiums, in turn, would result in more of an employee's compensation being received in the form of nontaxable employer-paid premiums, and less in the form of taxable wages. As a result of this shift, federal income and payroll tax revenues would decline. CBO estimates that enacting the bill would reduce federal tax revenues by $10 million in 2003, by $125 million over the 2003-2007 period, and by $375 million over the 2003-2012 period. Because the bill would affect revenues, pay-as-you-go procedures would apply.

Enacting S. 710 would not affect spending in the Federal Employees' Health Benefits program because participating health plans will meet the requirements of the bill under current law.

The bill's requirements for colorectal cancer screening would apply to health plans operated by state, local, and tribal governments for the benefit of their employees. It also would preempt some state laws that establish requirements for colorectal cancer screening. These provisions of the bill would be intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA), but the costs would not exceed the threshold established in UMRA ($58 million in 2002, adjusted annually for inflation).

The bill would impose a private-sector mandate, as defined in UMRA, on group health plans and health insurance issuers by requiring them to provide coverage of colorectal cancer screening for certain plan enrollees. CBO estimates that the direct cost of this mandate would equal about $110 million in 2003, about $240 million in 2004, and more in later years. Those amounts would not exceed the annual threshold established in UMRA ($115 million in 2002, adjusted annually for inflation) in the first year that the mandate would be effective, but would exceed the annual threshold in each of the subsequent four years.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of S. 710 is shown in the following table.

	By Fiscal Year, in Millions of Dollars					
	2002	2003	2004	2005	2006	2007
CHANGES IN REVENUES						
Income and HI Payroll Taxes (on-budget)	0	-5	-10	-20	-20	-30
Social Security Payroll Taxes (off-budget)	0	-5	-5	-10	-10	-10
Total changes	0	-10	-15	-30	-30	-40

NOTE: HI = Hospital Insurance.

BASIS OF ESTIMATE

The bill would require group health plans and health insurance issuers to provide coverage for colorectal cancer screening to all plan enrollees aged 50 and over, and to provide that coverage to certain high-risk enrollees under age 50. Plans would be required to cover the screening procedures specified in Medicare guidelines, including fecal-occult blood test, flexible sigmoidoscopy, colonoscopy, and double-contrast barium enema. The frequency with which those procedures would be covered would also have to be consistent with Medicare's guidelines. For example, plans would be required to cover one screening colonoscopy every 10 years for individuals who are not at high risk of colorectal cancer, and one colonoscopy every two years for individuals who are at high risk of colorectal cancer. High-risk enrollees would be defined using rules established for the Medicare program and would include those individuals with a family history of colorectal cancer, a prior diagnosis of colorectal cancer or precursor neoplastic polyps, a history of chronic digestive disease, or genetic markers for colorectal cancer.

The bill's requirements would apply to both self-insured and fully insured group health plans as well as plans sold in the individual market. In states with laws that require coverage of more comprehensive benefits for colorectal cancer screening, fully insured plans would be required to comply with the state law, while self-insured plans would be required to comply with the provisions of S. 710.

CBO's estimate of the cost of this bill is based on data about the use of colorectal cancer screening procedures among the privately insured population, the extent of current coverage of colorectal cancer screening in private health insurance plans, and the cost of performing each procedure that the bill would cover. CBO assumed that under the bill, utilization of colorectal cancer screening procedures among enrollees in plans that do not currently cover those procedures would grow to match the utilization rates of those procedures among enrollees in plans that do cover them. CBO estimates that among enrollees between the ages of 50 and 64, about 210,000 additional insured colonoscopies and 67,000 additional insured flexible sigmoidoscopies would be performed in 2003. Among enrollees at high risk of colorectal cancer, about 4,600 additional insured colonoscopies would be performed in 2003. The numbers of additional procedures performed as a result of the bill's enactment would grow in subsequent years.

CBO's estimate also takes into account the costs of follow-up care for individuals who receive newly covered screening procedures. Those costs include the cost of removing polyps identified by the screening, the cost of treating perforations of the colon (a side effect of both the screening procedure and polyp removal), and the cost of more frequent colonoscopies for individuals who were identified as being at high risk through a screening procedure.

Because some individuals who would have developed colorectal cancer will be identified through screening and have polyps removed prior to their becoming cancerous, our estimate includes the savings from treating those averted cancer cases.

CBO estimates that enacting S. 710 would increase premiums for private health insurance by an average of less than 0.1 percent, before accounting for the responses of health plans, employers, and workers to the higher premiums. Those responses would include reductions in the number of employers offering insurance to their employees and in the number of employees enrolling in employer-sponsored insurance, changes in the types of health plans that are offered, and reductions in the scope or generosity of health insurance benefits, such as increased deductibles or higher copayments. CBO assumes that these behavioral responses would offset 60 percent of the potential impact of the bill on total health plan costs.

The remaining 40 percent of the potential increase in costs, or about 0.03 percent of group health insurance premiums, would occur in the form of increased outlays for health insurance. Those costs would be passed through to workers, reducing both their taxable compensation and other fringe benefits. For employees of private firms, CBO assumes that all of that increase would ultimately be passed through to workers. We assume that state, local, and tribal governments would absorb 75 percent of the increase and would reduce their workers' taxable income and other fringe benefits to offset the remaining one-quarter of the increase. CBO estimates that the resulting reduction in taxable income would grow from $21 million in calendar year 2003 to $185 million in 2012.

Those reductions in workers' taxable compensation would lead to lower federal tax revenues. The estimate assumes an average marginal rate of about 20 percent for income taxes and the current-law rates for the Hospital Insurance and Social Security payroll taxes (2.9 percent and 12.4 percent, respectively). CBO further assumes that 15 percent of the change in taxable compensation would not be subject to the Social Security payroll tax. As a result, we estimate that federal tax revenues would fall by $10 million in 2003 and by a total of $375 million over the 2003-2012 period if S. 710 were enacted. Social Security payroll taxes, which are off-budget, account for about 30 percent of those totals.

PAY-AS-YOU-GO CONSIDERATIONS

The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in governmental receipts that are subject to pay-as-you-go procedures are shown in the following table. Changes in Social Security receipts are not subject to pay-as-you-go procedures. (Hence, the following table shows only the estimated changes in Income and Hospital Insurance Payroll taxes.) For the purposes of enforcing pay-as-you-go procedures, only the effects through 2006 are counted.

	By Fiscal Year, in Millions of Dollars										
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Changes in receipts	0	-5	-10	-20	-20	-30	-30	-30	-30	-40	-40
Changes in outlays	Not applicable										

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

The requirements in S. 710 would apply to health plans that state, local, and tribal governments operate for the benefit of their employees, specifically those that self-insure their benefit programs. Those requirements would be intergovernmental mandates as defined in UMRA. State, local, and tribal governments that do not self-insure their benefit programs, but rather contract with private health insurers, also would face increased premium costs, but the requirements (and hence the mandates) included in the bill would fall on the private plans. However, significant costs would be passed on to the state and local governments that purchase the health care coverage.

CBO estimates that state and local governments that self-insure would be directly responsible for providing regular screenings for colorectal cancer and would face increased costs as a result of the mandate of between $40 million in 2003 and $50 million in 2007. In no year would those costs exceed the threshold for intergovernmental mandates established in UMRA ($58 million in 2002, adjusted annually for inflation).

The bill also would preempt state laws that do not provide greater protection for colorectal cancer screening than the bill. This preemption would be an intergovernmental mandate as defined in UMRA because it would limit the application of state law. It would not, however, impose additional costs on state, local, or tribal governments.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The bill would impose a mandate on private-sector group health plans and health insurance issuers by requiring them to provide coverage of colorectal cancer screening for certain plan enrollees. CBO estimates that premiums for private health insurance would increase by less than 0.1 percent if the bill were enacted. The direct cost of the mandate in the bill would equal about $110 million in 2003, rising to about $450 million in 2007. That amount would not exceed the annual threshold established by UMRA ($115 million in 2002, adjusted annually for inflation) in the first year that the mandate would be effective, but would exceed the annual threshold in each of the subsequent four years.

PREVIOUS CBO ESTIMATE

This revised cost estimate supercedes the cost estimate that CBO transmitted on July 26, 2002. The revised estimate clarifies that health plans participating in the Federal

Employees Health Benefits program will meet the requirements of the bill under current law, as stated in the "Summary." There is no change in the estimated budgetary effects of the bill.

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